prevent such possible further danger in the event of a contingency that may or may not occur, or whether that risk is one that should be left to the decision of the patient. It it were necessary in the sense that it would be, in the circumstances, unreasonable to postpone the operation until a later date, I would say that as I read the authorities (vide *Marshall v. Curry* [1933] 3 D.L.R. p. 260 at pp. 275-276) the surgeon would have that authority. There are times under circumstances of emergency when doctors must exercise their professional skill and ability without the consent which is required in the ordinary case: (vide *Parmley v. Parmley* [1945] S.C.R. p. 635 at p. 646). On the other hand, ordinarily, as it is said in the same case at p. 645:

'The conclusion appears unavoidable that both of the parties hereto (there the doctor and dentist), particularly in the operating room failed to recognize the right of a patient when consulting a professional man in the practice of his profession, to have an examination, a diagnosis, advice and consultations and that *thereafter* it is for the patient to determine what if any, operation or treatment shall be proceeded with.'

"After citing the cases in support of that proposition, the passage proceeds:

'It may be that in the operating room, the parties hereto were of the opinion that they were acting in the best interests of (the patient) but that is not to the point. That would have been very important in their consultation with and their advising of (the patient) but it does not justify their proceeding without her consent.'

As was said by Garrison, J.: 'No amount of professional skill can justify the substitution of the will of the surgeon for that of his patient.' (*Bennan v. Parsonnet* [1923] 83 N.J.L.R. 20 at p. 26.)

"There are times under circumstances of emergency when both doctors and dentists must exercise their professional skill and ability without the consent which is required in the ordinary case. Upon such occasions great latitude must be given to the doctor or dentist.

"It was then stated that there were not there such circumstances but when she was under an anæsthetic was a convenient time.

". . ., the consultant, said that 97% of patients in such a situation as here when the patient was undergoing the operation, would be annoyed if the additional procedure were not taken. I do not think that is the point. The point is whether such an emergency existed, whether it was *necessary* that the operation be done, not whether it was then more *convenient* to perform it. It must be remembered that the effect of the procedure here was to deprive the plaintiff of the possible fulfillment of one of the great powers and privileges of her life. The possibility of her exercising that power or privilege may well be subject to risk but where is the necessity for an immediate decision? Where is the urgency? According to her evidence, which was not denied, she was advised later to have her uterus removed, because of the possibility of these fibroids degenerating and becoming malignant. She then took steps to obtain the advice of specialists both in gynæcology and with respect to cancer. Neither then discovered any reason for that action. I do not take this evidence as decisive of that fact that fibroids were not there or that these specialists by the examinations they made were better qualified to testify as the conditions existing than the surgeons attending on the Cæsarean operation. There is, however, no evidence that these tumours were presently at the time of operation dangerous to her life or health. The evidence is only that they *might* constitute a hazard in the event of a further pregnancy. That may go to the quantum of damages, but it does not, in my opinion, justify a 'trespass' to her person without her consent. I think therefore, she is entitled to judgment. It is not in my opinion a case where the conduct of the surgeons was such as to entitle her to punitive or vindictive damages, but I think they should be substantial. I would, in all the circumstances, assess the damages at $3,000.00."

ASSOCIATION NOTES

HEALTH INSURANCE*

William Magner, M.D., LL.D.(Hon.)

President, Canadian Medical Association, Toronto, Ont.

The doctors of Canada who are opposed to compulsory national health insurance, and I am one of them, are regarded, by certain sections of the people, as public enemies. We are told that it is only with state control of all medical services that the health needs of the people can be supplied, and we are accused of a desire to perpetuate a system under which large numbers of our fellow-countrymen are deprived of adequate medical care, for our own selfish ends.

Medical opposition to compulsory health insurance is not confined to Canada nor to any section of the profession. Doctors in New Zealand and in Great Britain fought, unsuccessfully, against State control, and in South Africa, Australia, and in the United States, as well as in Canada, they are firm in their stand against the socialization of medicine. If it is agreed, and I think it must be, that medical men have expert knowledge as to the conditions necessary for good medical practice, and that, as a group, they are competent, honour-

* Valedictory Address read at the Eightieth Annual Meeting of the Canadian Medical Association, in General Session, Saskatoon, June 15, 1949.

able, and devoted to the interests of their patients, is it likely, is it even credible, that they would be guilty of venality, that they would conspire to subordinate public welfare to private gain?

Avoiding any discussion as to whether or not it is morally justifiable and in accordance with Christian principles, for a State to force a section of its people to live and work under conditions which are abhorrent to them, avoiding also any inquiry as to the ultimate effect of socialistic measures on the character of the people, and the future of the country, let us examine compulsory health insurance from a materialistic viewpoint.

What the advocates of compulsory insurance have in mind, is that good medical care should be equally available to rich and poor. With this we are in complete agreement. For good medical care there must be good doctors, and the conditions of their practice must be such that they can give of their best to their patients. They must not be so overburdened by professional or clerical work that they are unable to find time for proper diagnosis, for study, and for needed recreation. They must not be subjected to bureaucratic control and curtailment of professional liberty. They must be given an opportunity to earn an income commensurate with their skill and training, and their standing in the community as members of a liberal profession. Failing these conditions, medical care cannot be good.

It is our thought, which almost amounts to a conviction, that these conditions cannot be satisfied under any scheme of national health insurance. They most certainly have not been satisfied in New Zealand, where a government health plan has been in effect for ten years, nor in Great Britain, which has had socialized Medicine for close to one year. From the general practitioners of both countries come bitter complaints of overwork. Their offices are so crowded by people with trivial complaints that they are unable to give to their sick patients the attention which is their due. Evidence is strong that the New Zealand plan is a costly failure, and the prospect of ultimate success in England, under the present régime, is not bright. Discussing the defects of the British Health Service, Lord Horder used these words:

> "Does someone say 'But this is only the doctors' point of view'? My reply is, 'There is no such thing as only the doctors' point of view'. Bureau or no bureau, the basic element in any Medical Service is, and must always be, the doctor. It was the crass folly of not recognizing this, and of assuming that personnel can be nationalized, that led to this colossal blunder."

The cost of the "colossal blunder", to the British taxpayer, has risen from the original estimate of £150,000,000 a year to £260,000,000 and it will certainly go much higher; 40% of all incomes in Britain are taken for taxes, as compared with about 25% in the United States and Canada, and roughly one-third of the whole government budget is expended on social services—a fact which *The Economist* calls "fantastic and appalling". Dr. Dain, Chairman of the Council of the British Medical Association, has expressed the grave dissatisfaction of medical men in Britain, in the following words: "If we do not get satisfaction quickly it will not be beyond the bounds of possibility to withdraw our services, not entirely because we are not getting enough money but because under the conditions obtaining we cannot properly 'deliver the goods' ".

There it is, in a nutshell. The majority of the doctors of Canada, and of the rest of the English speaking world, are opposed to compulsory health insurance because they fear that, under it, they will be unable to "deliver the goods". They fear, and they have good grounds to fear, that State control will lead to deterioration in the conditions of medical practice and in the quality of medical care, with disastrous effects upon the people. They also fear, for themselves, loss of dignity and independence, and economic insecurity.

We have every sympathy with the many thousands of people in the low and middle income groups, who demand protection against the high cost of medical and hospital services. We have every sympathy with our legislators who, exposed to relentless pressure from the proletariat, must, for their political lives, do something to satisfy this demand. But we do not believe that it is justifiable to risk the whole structure of Canadian Medicine in a colossal gamble, and, therefore, we cannot, in conscience, approve of any form of compulsory health insurance which has, so far, been proposed.

While we are opposed to compulsory health insurance, we have no desire to preserve an outmoded system of medical practice. Great things have been done under the old order, and with its passing some of the precious traditions of medicine, its great humanitarian principles, may find oblivion. But the tremendous advances in preventive, diagnostic, and therapeutic methods during the past quarter of a century, have greatly increased the complexity and the cost of medical services, and this, in turn, has led to inequalities in the standards of such services in different parts of the country and to different sections of the community. Something must be done about this.

I have little doubt that the problem of the provision of adequate medical care for people in the low and middle income groups, can be solved by proper reorganization and expansion of the voluntary health insurance plans which are now operating, under the direction of the medical profession, in every province in Canada. In the United States, these plans had one and a half million subscribers in 1944, five

million in 1946, and over ten million in 1948. I do not know what the total enrollment is in Canada, in Ontario it is now 250,000. These voluntary plans offer to people who can afford a modest monthly premium, complete or partial protection against the costs of medical services for themselves and their families. Subscribers consult the doctor or doctors of their own choice, and the intimate personal relation between doctor and patient, which is a prized tradition of Medicine, is maintained. Participating physicians are bound only by regulations approved by the medical profession at large, and administered by fellow practitioners.

It is true that the voluntary plans for prepaid medical care, as now constituted, do not solve the larger problems with which we are faced. They have nothing to offer those who cannot qualify as members of an employed group. They have nothing to offer the rural population nor, of course, the great mass of people who cannot afford the premiums demanded. It is also true that there are many doctors who are bitterly critical of the voluntary plans, inasmuch as there is no upper income limit for subscribers. The effect of this is that many people who are in easy financial circumstances, are enabled to obtain medical services for minimum fees—fees which are set by the medical profession solely for the benefit of persons in the low income brackets. I am one of those who think that this is wrong.

What changes must be made? How can the voluntary plans for prepaid medical care be moulded to fit the needs of the country? These are my ideas, for which I claim little or no originality.

1. The activities of the various provincial Plans must be coordinated. (This is already under way. The Canadian Medical Association is negotiating with the Secretary of State for the formation of an organization, under the title "Medical Care (Canada) Incorporated".)

2. The Plans must extend protection to individuals as well as to groups, to the rural as well as to the urban population. (There is little doubt that most of the Plans will accomplish this in the near future.)

3. The Plans must agree to accept as subscribers only those whose net or taxable income is below (say) $3,000 a year.

4. The doctors, both specialists and general practitioners, must agree to attend all subscribers to the Plans for the minimum fees set by the Division of the Canadian Medical Association in the province in which they reside.

5. The governments of Canada must agree to subsidize the medical care of those who are living "on the thin edge of things", through the voluntary plans for prepaid medical care which are approved by the medical profession.

6. The federal government must agree to permit subscribers to these Plans to reduce their taxable incomes by the amount which they pay in premiums.

The suggestion that governments might subsidize the medical care of poor people, through the approved voluntary plans of health insurance, is not new or revolutionary. For many years, the Ontario Government has done just this, in providing partial medical care for the Welfare Group, through the Ontario Medical Association. This year the government of British Columbia has agreed with the provincial medical profession to provide funds for the complete medical care of these people. Thus, two of our provincial governments have shown their confidence in our integrity, and in our ability to run a health insurance plan without interference from the legislative body.

It may be argued that the cost of the scheme which I have outlined would be great. This may be true, but is there any doubt that the burden on the taxpayer would be less than under a plan of compulsory health insurance? I would ask you to look again at the staggering cost of socialized Medicine in Great Britain, and in New Zealand, where, we are told, the cost of the social security program comes to sixty dollars per head of the population.

Socialized Medicine means a crushing burden on the taxpayer. Socialized Medicine means a harassed medical profession, deprived of all that now attracts clever and high-minded men and women to a medical career. Socialized Medicine means an inferior medical service, staffed, in time, by inferior men. Socialized Medicine is the first step, and a long step, towards the Gehenna of the Welfare State.

I will close with two quotations. The first is from Dr. Ffrangcon Roberts who, writing in the *British Medical Journal* of February 19, 1949, has this to say to the British doctors:

> "We must not allow absorption in the daily round to prevent us from counteracting the hysterical clap-trap of demagogues, the impractical visions of idealists, or the false promises of academic theorists. We must proclaim the faith that is in us, the faith inspired not by the Blue Book but by the bedside, not by Sidney Webb, but by Hippocrates, not by the London School of Economics but by the Island of Cos."

The other quotation is from Thomas Babington Macaulay who, more than one hundred years ago, wrote in the *Edinburgh Review*:

> "Our rulers will best promote the improvement of the Nation by strictly confining themselves to their legitimate duties, by leaving capital to find its most lucrative course, commodities their fair price, industry and intelligence their natural reward, idleness and folly their natural punishment; by maintaining peace, by defending property, and by observing strict economy in every department of the State. Let the Government do this, and people will assuredly do the rest."

FROM THE CHAIR

Harris McPhedran

Chairman of Council

It has always been an instructive if exhausting experience to preside over meetings of the Council. At no time can eyes be dim or ears dull, if rules of procedure are to be observed and arguments followed. The Chair is a place of advantage whence to sense the force of argument and play of emotions.

It was interesting to observe the swing of opinion as this one, pale, tense and logical—that one, red, excited and explosive, discussed the subject of debate. Between these extremes, came the still small voice of calm—always salutary.

The spiritual values loomed large in discussion. How can medical services be adjusted to meet best the needs of the public was the key note, with lesser concern about monetary reward.

Throughout, the discussions were on a high level with none of the intemperance of some assemblies. This is a tribute to minds trained to sifting evidence in their daily routine.

Time and time again, the advice was to go slowly in any contemplated changes, not to destroy what has been found useful, but to build on the solid foundation of experience of a vocation with a great tradition. Changes were conceded to be inevitable and this is in keeping with the tradition of medicine. The majority of opinion was that in these changes the profession of medicine should take the lead, with a definite policy (now adopted) to be placed before the people of all walks of life for their consideration and constructive criticism. This is work for the Public Relations Committee.

The discussions of the Council were constructive throughout and the results definite, whether or not such stand the test of time. We have nothing to fear from experiments well planned, tried and proved, good or bad. We still progress through trial and error.

The Chairman would be remiss, if this opportunity were not seized to thank each and every member of Council who came, listened or spoke, stayed even into the early hours of the morning and voted according to the dictation of his conscience.

My thanks to each and all.

In the case of the medical profession, the more distinguished it is and the more serviceable to the world, the more unrestricted it should be for those who practise it. It is only just that the art of healing should carry with it some privilege in respect to the liberty of practising it; that it should not be subject to enslavement by the law, or to voting and judicial punishment or to fear and a father's threats and a layman's wrath.—*Lucian.*

MEDICAL SOCIETIES

ROUND TABLE CONFERENCE ON SODIUM PENTOTHAL*

Chairman
Dr. G. A. Wainwright, London

Members of Panel
Dr. W. N. Hardman, London
Dr. H. G. Norry, London
Dr. C. A. Stewart, Chatham

Dr. Wainwright: Sodium pentothal is an anæsthetic which is becoming more extensively used, particularly for induction. There is a very fertile field here for instruction to the occasional anæsthetist who is using sodium pentothal for induction and short procedures. This casual anæsthetist won't undertake cyclopropane or nitrous oxide and oxygen, but because of its apparent simplicity he is using sodium pentothal more and more frequently. This is not to be condemned if he has a proper appreciation of the limitations and the restrictions to be observed in its use. He should also have the ability and equipment to deal with such emergencies as may arise.

Dr. Hardman (Indications and contraindications).

Some authorities state that the chief indication for the use of sodium pentothal is the ability of the anæsthetist to use the drug properly. I would not agree with this statement in its entirety. There are cases in which if it is used it should be used with great caution. Since Lundy introduced sodium pentothal in 1934 the indications for its use have increased greatly. It is now widely used for the induction of patients. It relieves apprehension and there is frequently retrograde amnesia. The incidence of nausea and postoperative vomiting is reduced with this anæsthetic agent.

Sodium pentothal is also used to anæsthetize the patient during local, regional, or spinal anæsthesia. Many of these procedures cause considerable discomfort and a small amount of sodium pentothal may be advantageously used to render the block painless. At the completion of the block the patient may be allowed to wake up and the surgical procedure continued under the local, regional, or spinal anæsthetic. Sodium pentothal is a valuable anæsthetic for operations about the face and neck in which it is impossible to apply a mask to the face because of the site of the operative field. In these cases an intratracheal tube may be inserted if the larynx and pharynx are cocainized prior to the administration of the sodium pentothal. This anæsthetic is also valuable for bronchoscopy, œsophagoscopy and other endoscopic procedures. Curare may be used to advantage in these cases, in the proportion of one unit of curare to one c.c. of 2½% sodium pentothal. Sodium pentothal is the anæsthetic of choice in procedures in which the electrocautery or diathermy are used, as it precludes the danger of explosion.

Sodium pentothal is widely used for minor procedures such as changing casts, manipulation of painful joints and manipulations in which spasticity of muscle is present as in poliomyelitis. In these cases the combination of sodium pentothal plus curare is advantageous. This anæsthetic may also be used in chest surgery if the pleural cavity is not opened and in operations on the chest wall.

Sodium pentothal should not be used with any patient who is suffering from dyspnœa, either from cardiac or pulmonary disease. It should be used very cautiously in anæmic patients, particularly if the red blood cell count is less than 2,500,000 and the hæmoglobin less than 50% or 7 grams. In these cases the oxygen-carrying power of the blood is restricted. Sodium pentothal should not be

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* Section on Anæsthesia, Canadian Medical Association Convention, Toronto, Canada, June 24, 1948.